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Awareness and Acceptance: A Critical Analysis of the Theories of Health and Change in Gestalt Therapy and Acceptance and Commitment Therapy

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AWARENESS AND ACCEPTANCE: A CRITICAL ANALYSIS OF THE THEORIES OF HEALTH AND CHANGE IN GESTALT THERAPY AND ACCEPTANCE AND COMMITMENT THERAPY

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Introduction

A guiding issue for psychology as a field has been how the question, "What is health?" is conceptualized. In the development of psychology as a health profession, many psychologists have looked to and taken from their colleagues in the medical sciences. These psychologists have adopted an understanding of health as defined by a lack of disease, a concept encapsulated in the recent literature as an *assumption of healthy normality* (e.g., Hayes, Strosahl, & Wilson, 1999). This assumption was based in a conflict model, a conflict between "normalcy," which is inherently healthy, and "disease," which blocks or disrupts this inherent health. Though this conceptualization has been useful and compelling for biological pathology and physical illness, it has become vague and reductionistic when translated to the field of mental health. Despite this problem, many early models of psychological health were conflict models, the most popular and comprehensive model being the drive theory set forth by Sigmund Freud (Freud, 1938/1995). Briefly, the traditional Freudian drive theory involved an overall conflict between innate human urges for pleasure through sexual and aggressive behaviors and the constraints of the outside world, especially regarding the rules of conduct in human society. The mediator of this conflict was the ego, which attempted to balance expression of pleasure-seeking drives with the limitations of proper behavior in society. Conflict models have continued to the present with more contemporary orientations such as cognitive-behavioral therapy (e.g., Hayes, 2004a).

Some psychologists who have been dissatisfied with conflict models have replaced them with holistic models. Whereas conflict models are based on a conceptualization that health can be defined as the lack of illness, holism models are based on a definition of health in terms of relative functionalism and the context of the behavior for the individual (Ansbacher & Ansbacher, 1956). In other words, those who employ holistic models recognize that the whole of healthy human experience includes exposure to negatively-judged occurrences, ranging from unsatisfying relationships with others to distressing internal responses to situations, such as sadness or anxiety. With this as a foundation, health in holistic models is defined and understood by how individuals respond to these occurrences given their particular historical and situational contexts, not the absence of these occurrences. What exactly is your experience right now? Is this experience specific to the present situation or is it a common pattern in a variety of contexts? How would you proceed in responding to the situation, taking into account the current internal and external environments? These are some of the questions that are important to holistically-driven therapists. As evident with those questions, common themes in holistic psychological models include awareness of the present situation (e.g., Hayes, 2004b; Zahm & Gold, 2002) and the amount of attention and choice there is when responding to the situation (e.g., Hayes et al., 1999; Perls, 1973).

Though there are many therapies that would be considered holistic, it would be beyond the scope of this paper to explore them all. Instead, two psychotherapeutic approaches will be presented which embody holistic philosophies and intervention styles. Gestalt therapy will be the first approach presented, an approach that has traditionally

been understood in terms of its holism and a primary goal of increased awareness in the present moment (e.g., Latner, 1986; Perls, 1973; Zahm & Gold, 2002). The other approach that will be presented is acceptance and commitment therapy (ACT; Hayes et al., 1999), one of many behavioral therapeutic systems that have derived interventions from the mindfulness training of Buddhism. In the recent literature, such systems have been known as *mindfulness-based interventions* (Baer, 2003) or *the third wave of behavior therapy* (Hayes, 2004a, 2004b). As a comprehensive treatment with its own elaborated philosophy, theory, and interventions, ACT is an excellent representative of mindfulness-based interventions and is different from other similar treatment protocols.

The purpose of this paper will be threefold. First, I will delineate the parallels and distinctions between the holistic notions of health and change in Gestalt therapy and ACT. Next, I will present selected concepts and values within ACT and argue how those concepts and values could enhance Gestalt therapy based on a more behaviorally-informed vocabulary. I will further argue that these concepts and values provide Gestalt therapists with a process for engaging in empirical studies and overcoming a major obstacle to the implementation of Gestalt therapy in the mental health community, namely the structured and behaviorally-oriented criteria of managed care providers. I will also discuss how the philosophy and theoretical base of ACT uses important concepts which are already a part of Gestalt therapy, despite reaching those concepts from behaviorist origins. From this discussion, I will discuss some deficiencies in ACT clinicians' implementation of these traditionally humanistic concepts, and how the theoretical and philosophical perspectives of Gestalt therapists may help address these deficiencies. The main goal of this paper is the

integration of these two approaches. Both of these approaches have similarities that reveal an important central theme that therapists are exploring with regards to mental health, as well as contain differences that allow for critical discussions in improving and advancing the field of psychology as a whole.

Gestalt Therapy

Gestalt therapy was initially conceived as a departure from psychoanalysis by its co-founders, Frederick (Fritz) Perls and Laura Perls. Eventually, Gestalt therapy became its own separate orientation with the publication of the book *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls, Hefferline, & Goodman, 1951). Since the release of that book, numerous texts and articles have been written describing the philosophical foundations, theoretical standpoints, and methodological intricacies of Gestalt therapy. Detailing that basic material is beyond the scope of this thesis. Instead, in this section, I will focus on particular aspects of Gestalt therapy pertinent to understanding how Gestalt therapists conceptualize health and change within the framework of their orientation.

Health in Gestalt Therapy

Gestalt therapists have held natural, organismic self-regulation as the grounding premise in understanding health. Fritz Perls extended the biological notion of homeostasis into the psychological world, namely that human psychology is guided by a natural process of self-regulation between individual needs and environmental factors (Perls, 1973; Perls, Hefferline, & Goodman, 1951). When a need arises, an individual attends to the need by gauging the field, which includes both the internal (i.e., intrapsychic) and external (i.e., interpersonal and physical) environments, and determining how the field would be able to

meet that need.

Gestalt therapists have used the heuristic of the cycle of figure formation and destruction in understanding the process of organismic self-regulation. The general outline of this cycle includes a variety of stages that an individual goes through when encountering a *figure*, or that which is "a focus of interest or attention" that is "generally related to a need or desire" (Zahm & Gold, 2002, p. 863). The first stage of the cycle is *sensation*, or the psychophysiological experience of a figure. In the *awareness* stage, a discrimination and clarification of the figure occurs. Next, comes *excitement*, as the field is scanned in order to assess which elements of the environment will attend to the figure and energy is mobilized. Once the field is assessed, *action* is taken to attend to the figure or need. The moment of engagement between an individual and the environment is known as *contact*. Through the contact process, the experience is *assimilated*, or integrated within the individual. Finally, comes the stage of *closure*, which occurs when the figure of interest recedes (presuming that it was attended to adequately), which then allows for a new figure of interest to arise.

From this standpoint, Gestalt therapists conceptualize healthy functioning as aware and integrated free-functioning figure formation and destruction (Latner, 1973). However, another aspect of healthy functioning is also apparent to Gestalt therapists. Gestaltists acknowledge that interests and needs cannot always be directly attended to and satisfied due to specific field conditions that may be present. During these situations, the individual is thought to adapt in the best way possible based on the field conditions (again, taking into account both internal and external environments), which Gestaltists refer to as a

creative adjustment. Creative adjustments provide a manner in which individual needs can get met in some way when a more direct fulfillment of the need is unavailable. Thus, creative adjustments facilitate an alternate method where the cycle of figure formation and destruction can flow based on the unique characteristics of the field conditions at the moment.

A chronic and pervasive unawareness in an individual's experience coupled with restricted contact with the environment have been the traditional foundation for how Gestalt therapists conceive of unhealthy functioning. Whenever there is a disconnection between an individual's needs and what is available in or required by the field, an individual will always creatively adjust. As natural as the process of creative adjustment is, creative adjustments can become rigid, outdated, and enacted without awareness, resulting in difficulties for the individual in his/her interactions with the world. In this case, the creative adjustment no longer facilitates healthy figure formation and destruction, but interrupts the cycle in a manner which provides unsatisfactory attention to the figure of interest. Without fulfillment of the figural need, closure is not attained and the cycle of figure formation and destruction is interrupted. When this interruption occurs, the unfinished figure fades into the individual's background. The background is the total experiential periphery where all possible figures "reside," as well as the backdrop that attended figures are placed upon. The natural tendency of figures is attention and completion, and figures residing in the background compete with any figures that are presently being attended to for closure. This competition can impede or complicate the completion of such presently arising figures. Since the incomplete figure is in the

background, it resides outside of awareness, and proper attention to secure closure for that figure is not generally acknowledged (Yontef, 2005).

As an example of this concept, imagine the case of a man who seeks to express his needs vocally to others but as a young boy experiences events that inhibit his ability to state his needs, such as being told he should be more self-sufficient and independent. The next time his need for verbalizing his needs to others arise, he may creatively adjust by refraining from asking others for help and, instead, engage in a private conversation with himself about getting whatever needs met. Let us assume that this is a regular strategy that the man employs whenever interpersonal needs arise within him. As an adult, he has a need to verbally express his desire for physical and emotional closeness in intimate relationships. His creative adjustment is engaged, and instead of vocalizing his interpersonal need to his partner, he talks to himself. Although the vocalization occurs, the underlying need for closeness is not met, and this figure recedes into the man's background. Since this need for closeness has not been completed and now resides within his background, it can compete with other more presently occurring figures for closure. For instance, if the man wishes to be assertive in expressing activities that he wants to do and disagreeing with doing activities that he does not enjoy whenever going out with friends, this figure may be in competition with the incomplete figure of closeness. The result might be that the man routinely agrees to take part in activities that he really does not want to do. The incomplete figure of closeness remains in the background, unattended and unfulfilled.

Gestaltists have identified particular processes that have the potential to inhibit the

full and healthy flow of the cycle of figure formation and destruction. These processes are understood to take place at the space between the individual and the individual's environment, also known as the contact boundary. Thus, these processes are given the label of *contact boundary phenomena*, of which five are traditionally identified and accepted by Gestalt therapists: introjection, retroflection, projection, deflection, and confluence (e.g., Polster & Polster, 1973).

Introjection is the process of taking in information or aspects of the environment without fully assimilating and integrating it into the self. This process is typically seen with the acceptance of "shoulds" with regards to how you should feel, think, or act without any critical assessment or discrimination. *Retroflection* involves directing inward energy that would normally be put out into the environment to meet needs and wants. This can take the form of suppressing your needs and wants completely or doing for the self something wanted or desired from the environment. *Projection* is a process of placing ownership of feelings and thoughts on another person rather than on yourself. For example, an individual uncomfortable with feelings of anger might project those feelings onto his/her employer, thus, thinking that his/her employer is angry with him/her whether or not that is actually the case. The process of *deflection* involves using behavior to lessen intense emotional or interpersonal contact. Common examples of deflecting include averting eye contact and laughing while talking about uncomfortable situations. Finally, *confluence* is a process where an individual ignores or denies the boundary between self and other. As a result, awareness and expression of personal needs and wants becomes completely contingent on the needs and wants of another person, these needs often suppressed in

favor of another's experience.

Implicit in this conceptualization is the idea that creative adjustments and the contact boundary phenomena are not totally unhealthy processes. In fact, creative adjustments are practical adaptations to an ever-changing environment, and contact boundary phenomena can aid in the formulation of healthy creative adjustments. It is when these processes occur without awareness and become rigidified (unresponsive to the nuances of the current field conditions) that creative adjustments and contact boundary phenomena become obstacles to healthy functioning. With this in mind, Gestalt therapists have a unique outlook how change occurs within therapy.

Change in Gestalt Therapy

For Gestalt therapists, healthy figure formation and destruction not only provides a heuristic for understanding experience, it also sets forth the foundation for how change is conceptualized. In terms of natural change processes, an individual who meets needs through direct action and contact or through the use of creative adjustments, facilitates expression and completion of those figures. Through the lens of increased awareness, an individual can choose his/her course of action in responding to a perceived need or want, determine if direct action and contact is possible in the field or if a novel adaptation needs to implemented. Furthermore, past creative adjustments can be used just as easily if aware discrimination of the field conditions support their use.

As stated previously, nonoptimal functioning occurs when rigid or outdated creative adjustments are used without awareness. Clients often seek therapy to be given

tools as to how to be a different individual, since their tried-and-true methods (i.e., creative adjustments) are not working for them with their particular situation or presenting problem. Indeed, psychoeducation and skills training have become a part of many types of psychotherapies. Though Gestalt therapists are not necessarily adverse to using psychoeducation or skills training in session, the theoretical underpinnings of authentic and effective change for an individual that guide Gestalt therapists paradoxically involves a principle of "not changing."

In describing this theory, Arnold Beisser christened it the *paradoxical theory of change* within Gestalt therapy (Beisser, 1970). This theory stated that change occurs when an individual becomes what he/she is, instead of attempting to become what he/she is not. On the surface, this theory seems nonintuitive: If a client is in distress about the way his/her life is, how would change come about by not trying to change? However, like all sound paradoxes, the truth of the paradoxical theory of change lies in its grounding theory. With Gestalt therapy's notion of healthy or optimal functioning derived from the thorough and satisfactory flow of the cycle of experience, or figure formation and destruction, change is a natural process that occurs without any intentional effort or energy being placed into it. Given satisfactory attention, an individual's figures of interest will naturally arise and fall away. When the cycle is interrupted – that is, when effective and satisfactory closure of a figure is not achieved – then the unfinished figure recedes into the individual's background, out of awareness, where it remains because of the lack of closure. During its tenure in an individual's background, the unfinished figure complicates the closure of other figures that are being attended to, which may lead to eventual distress

and symptomology for the individual.

The presence of unfinished figures in the background may complicate or even prevent the completion of new figures, as seen in the earlier example of the man and his unsatisfied need for closeness. By adopting the paradoxical theory of change, the unfinished figure that remains in the background is attended to by "becoming what one is." Once the unfinished figure receives the closure it lacked in the past, that figure will finally recede, allowing the cycle of experience to continue without background hindrances. An individual attempting to "become what he or she is not" ignores the unfinished figure that resides in the background. The individual becomes occupied with more new figures. However, coming up with a barrage of new figures will not promote therapeutic change. Using the earlier example of the man and his need for closeness, "becoming what one is" would be seen as the man becoming fully aware of his need for closeness and his need to express it to others. "Becoming what one is not" would be seen as filling the man's experience with a variety of other figures that will not actually attend to closing the incomplete closeness figure, as was illustrated in the example.

Unfinished figures are accessed through the creative adjustments that were born from them, and Gestalt therapists work with these adjustments through the framework of the contact boundary phenomena and the process-oriented behaviors that are expressed through them. The goal for Gestalt therapists is to increase their clients' awareness, allowing for an expanded experience of self. This increased awareness of themselves grants clients the ability to be less limited in their responses to their needs in relation to their environments. Gestalt therapists guide their clients in this process by adhering to a

tripartite philosophy of bracketing off subjective interpretation in favor of observable behaviors, the philosophy of *phenomenology*; recognizing and understanding the totality of one's internal and external environment, as well as how the therapist is also a part of that system, or the philosophy of *field*; and cultivating an environment in session that allows for equal interaction between client and therapist, as well as facilitating the experience of humanity of each other, or the philosophy of *dialogue* (Parlett, 2005; Yontef, 2005; Zahm & Gold, 2002). In practical terms, this three-part philosophy is expressed in session through the use of creative *experiments* (Melnick & Nevis, 2005).

Gestalt therapists use in-session experiments to facilitate the two general goals of Gestalt therapy: heightening the client's awareness of self and allowing the client to have an expanded experience of self and environment. Gestalt experiments are not systematic techniques, but rather rely on the therapist's creative use of behavioral observations in the session (Zinker, 1977). Experiments have no specific expected outcome other than to help cultivate the dual goals mentioned previously. Even if a client is reluctant or resistant to engage in an experiment as articulated by the therapist, important work can be done surrounding the client's experience regarding his/her reluctance or refusal. It has been argued that despite the focus on "behavior" in session, Gestalt therapy is distinct from traditional forms of behavior therapies because Gestalt therapists include subjective experience as a behavior (Kepner & Brien, 1970). The use of experiments also shifts Gestalt therapy from traditional "talk" therapy about hypothetical situations to more action-based therapy couched in present experience (Zinker, 1977). The effectiveness of experiments is gauged by how much more awareness the client experiences, as well as

how that increased awareness can allow for more choice in behaviors and responses in his/her life outside of the therapy room.

Acceptance and Commitment Therapy (ACT)

Over the last few decades, practitioners have developed a new approach that integrates cognitive-behavioral therapy (CBT) and aspects of Buddhist mindfulness. The extent of that integration varies within such mindfulness-based interventions, ranging from the use of more formalized mindfulness meditation practices, as is the case with treatments such as mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002), to utilizing mindfulness-related philosophy and identified mindfulness mechanisms, as is the case with systems such as dialectical behavior therapy (DBT; Linehan, 1993). It would be beyond the scope of this paper for me to outline and explore each and every nuance within the mindfulness-oriented movement. Many authors have presented discussions of the different strands of mindfulness-based interventions and the basic philosophy and mechanisms that underlie the integration of CBT and mindfulness (e.g., Baer, 2003; Hayes, 2004a; Orsillo, Roemer, Block Lerner, & Tull, 2004). To narrow down the nascent field of mindfulness-based interventions, I will focus on acceptance and commitment therapy (ACT; Hayes et al., 1999) as its primary representative. I have chosen ACT to represent mindfulness-based interventions as a whole for three reasons: (a) ACT is comprehensive in its philosophy and theory as a stand-alone treatment, (b) ACT and its authors are among the most cited resources within the mindfulness-based treatment literature, and (c) the originators of ACT provide enough structure to be adapted to most any therapeutic situation without becoming a fully established manualized treatment. As I did in the Gestalt therapy section, in this section I will focus on elements of ACT that are

important in understanding how ACT therapists conceptualize mental health and therapeutic change within their framework (see Hayes & Strosahl, 2004, for more information on specific uses and applications of ACT).

Acceptance and Commitment Therapy as a Mindfulness-Based Intervention

It can be easily discerned that certain cognitive-behavioral interventions are derived from the concept and process of mindfulness as explicated within Buddhism. For instance, clinicians' development and use of formal sitting meditation within mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and MBCT reveal the obvious connection between the interventions and Buddhist mindfulness. However, other interventions that do not rely on such obvious modes of mindfulness seem more abstract and difficult to associate with mindfulness. ACT falls into the latter category, that is a therapeutic intervention not specifically conceptualized within the framework of mindfulness within the primary manuals of the approach (Baer, 2003; Hayes et al., 1999). In such a case, how is ACT associated as a mindfulness-based intervention? The answer lies in how psychologists have begun to mechanize the mediating factors within mindfulness training, and how such mediators have been applied in treatment protocols.

Baer (2003) presented five mechanisms that many mindfulness treatment protocol authors have suggested as mediators to symptom reduction and behavior change: exposure, cognitive change, self-management, relaxation, and acceptance. For mindfulness treatment practitioners, exposure, a hallmark intervention in behavioral treatments for anxiety related symptomology (Barlow, 2002), involves the client directing nonjudgmental

attention to any and all sensations, such that overall stress is reduced. Cognitive change is similar to exposure, but mindfulness authors differentiate it from exposure by focusing on directing a nonjudgmental attention towards thoughts and attitudes about thoughts. This practice is understood to cultivate a realization that thoughts are just mental events that do not necessarily reflect reality or truth. Self-management refers to process where individuals are provided with optimal self-observation skills and tailored coping strategies with regards to particular situations or symptomology. Relaxation has been correlated with mindfulness training, but has been understood by many mindfulness-oriented psychologists as being epiphenomenal to the primary role of mindfulness as a process of cultivating a nonjudgmental attention to events. Yet the role of relaxation has also been presented as a contributing factor to the effectiveness of such treatments (Baer, 2003). Finally, acceptance is understood to be related to exposure in that experiences, even negatively-judged ones, are to be experienced and accepted as "what is going on at the present moment." It is only when this occurs that individuals may truly act with regards to negative symptomology or experiences in a manner which is optimal for their functioning.

Although several authors have attempted to operationalize mindfulness from a Western psychological standpoint (Bishop, 2004; cf. Brown & Ryan, 2004), there are no current criteria in the literature which outline what defines an intervention mindfulness-based. As mentioned previously, any treatment protocol that has been developed with a presentation of mindfulness meditation can be easily labeled as a mindfulness-based treatment, but there have been arguments from some mindfulness authors for basing mindfulness within a sound philosophical and theoretical framework rather than

associating it with any given technique or independent system, including meditation (Hayes & Shenk, 2004). As a result, it may helpful for the purposes of this paper to adapt a working criteria for a mindfulness-based intervention based on the five mechanisms outlined previously.

Specific methods and techniques within ACT will be discussed later in this section. First, however, I will describe how ACT fits into the five mechanism criteria with the purpose of determining if it is truly a mindfulness-based intervention. ACT therapists tend to work more with interoceptive exposure, since their work focuses on the link between private (verbal) events and symptomology for individuals. ACT therapists enact techniques to aid the individual in gradually becoming more able and willing to increase their contact with private events that were previously avoided (Hayes et al., 1999; Hayes & Wilson, 2003). Cognitive change is quite evident in ACT treatment, as Hayes et al. (1999) acknowledge that much of the problems that individual face have a verbal-linguistic element and that one of the intervention strategies that ACT therapists rely upon is the loosening of literal associations between mental events and experiential reality. ACT therapists further address self-management skills not only with tools and training to increase awareness of one's self with regards to situational or historical distress, but also provide a system that makes such training easy to be used outside of the therapy room (e.g., the use of acronyms to conceptualize a variety of lists or steps, as well as the application of imagery-provoking metaphors). Acceptance is a paramount concept within ACT, as can be inferred by the inclusion of this mechanism in the treatment's name. Hayes et al. (1999) argue that most individuals engage in experiential avoidance, that is enacting

behaviors to avoid unpleasant or distressful experiences even if the enacted avoiding behavior is more harmful or maladaptive than the distressful experience. ACT therapists hypothesize that if individuals could begin by accepting that certain unpleasant or distressful experiences may occur on occasion and these experiences are not life-threatening and are temporary states, such negative experiences would become "unpleasant but brief experiences to be tolerated, rather than fearsome and dangerous experiences to be avoided, even at the cost of significant maladaptive behavior" (Baer, 2003, p. 130).

The only mindfulness mechanism that ACT does not address directly is relaxation. However, many mindfulness protocol authors identify relaxation as epiphenomenal and though some protocols may use meditation training (e.g., MBSR, MBCT) that may mirror some relaxation interventions, even those therapists recognize that the purpose of the meditation training is not primarily relaxation, but the retraining of attention and awareness. ACT therapists do not institute any formal or informal meditation training (see Hayes & Shenk, 2004, for a discussion on the distillation of mindfulness from associations and attachments to specific techniques), but this is not to imply that relaxation interventions could not supplement the ACT protocol. However, ACT therapists center on the destructive component of human language, how verbal relationships contribute to suffering and distress, and the process by which verbal-linguistic elements shape increased reliance on private, ideational experiences rather than on direct experience.

Health in Acceptance and Commitment Therapy

Working from the CBT model of mental health, ACT therapists began to challenge the implicit assumption adopted from physicians and medical scientists with regards to their "medical model," namely that disease is anomalous and that health is inversely related to the amount and intensity of symptomology (Hayes et al., 1999; Wilson & Murrell, 2004). The application of the medical model was labeled the *assumption of healthy normality*, and its analog in psychology was that "psychological health" is the normal or baseline state, which can be interrupted by the presence or emergence of an abnormal pathological condition, referred to as disease or illness (Hayes et al., 1999). From a behavioral perspective, mental illness would be understood in terms of a pathological learning history that led to the experienced negative thoughts, emotions, and behaviors (Wilson & Murrell, 2004).

The alternate view of health that ACT therapists posit is what they refer to as the *assumption of destructive normality*, which recognizes that "ordinary human psychological processes can themselves lead to extremely destructive and dysfunctional results and can amplify or exacerbate unusual pathological process" (Hayes et al., 1999, p. 6). ACT therapists acknowledge that the learning processes that contributed to mental illness are no different from the learning processes that generated nonpathological patterns (Wilson & Murrell, 2004). For the ACT therapist, the learning processes to be explored are related to the foundation for language.

CBT therapists have recognized that certain psychological symptomology, such as anxiety, have had a verbal-linguistic element that triggers and maintains that symptom

(e.g., Borkovec, 2002; Borkovec & Inz, 1990; Roemer & Orsillo, 2002). Some behavior analysts have explored language and have identified and elaborated upon certain aspects of human language that engender types of distress and suffering specific to humans (Hayes, Barnes-Holmes, & Roche, 2001). To conclude that human language is problematic, however, is not the point of this line of thought. Instead, human language is recognized to be a complex process that in a particular context can contribute to an individual's beneficial or hindering responses to the environment. In other words, psychopathology is not conceived of as an anomaly to healthy functioning, but rather born from the same processes and conditions as healthy functioning. Here, the subtle shift is from reifying some "pathogen" as a cause for mental health issues to identifying the emergence of mental health issues as derived from the interrelated context that cultivates the meeting of psychological and physical factors.

ACT therapists understand the process of psychopathology with the acronym FEAR: fusion, evaluation, avoidance, and reason giving (Hayes et al., 1999). *Cognitive fusion* occurs when behavioral functioning is primarily derived through thought and verbal regulation rather than by direct experience. Though this process can be quite beneficial, such as in the case of preparing for a potentially threatening situation for the first time and assessing the situation through thought before direct experience, cognitive fusion as a routine strategy is problematic since its use reinforces behaviors to become increasingly insensitive to direct experience. In other words, people begin to live inside their heads instead of living in the world. *Verbal evaluation* is essentially synonymous with making comparisons between ideational expectations and actual experienced outcomes. Verbal

evaluation is the foundation for problem solving and planning, when conceptualized consequences and outcomes can be assessed. However, verbal evaluation can also lead to great suffering and dissatisfaction if internalized or imagined expectations lead an individual to chronically judge his/her real-life progress as failures if the actual outcomes do not match the conceptualized ideal (even if such outcomes are still beneficial or appropriate to the situation). *Experiential avoidance* is a three-step cyclical process that an individual may engage in when experiencing a particular private event (e.g., physical sensation, emotion, memory, thought): (a) the individual recognizes the event as "negative" or "unwanted" and seeks to break or interrupt contact with the event; (b) the individual takes steps to alter the form, frequency, or sensitivity of the event; (c) the individual's ways of avoiding the event actually facilitate the event's reoccurrence, especially since the standard management techniques require thinking about the event to be avoided (e.g., Roemer & Borkovec, 1994). *Reason giving* has been defined as a procedure whereby the person is drawn into attempts to understand and explain as a method of controlling the outcome of a given situation. Reason giving tends to increase experiential avoidance and resistance to actual change because the person fears being wrong or incorrect (Hayes, 2002). ACT therapists acknowledge that many of the elements of FEAR are key aspects to a variety of problems including mood issues, anxiety diagnoses, and substance abuse (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996).

For the ACT therapist, psychological health is not the absence of "disease" whereby all life experiences are pleasant and without any conflict or frustration. Instead, ACT therapists understand health as an individual's ability to live life in accord with

chosen values, while being able to maintain an open and nondefensive contact with private events as they arise from both expected and unexpected situations. From this reformulation of health, ACT therapists not only have an accurate description of reality, but also understand that regulating and decreasing human suffering in life is based upon inaccurate and ineffectual formulations of living.

Change in Acceptance and Commitment Therapy

If one accepts how ACT therapists conceive psychological health and disease – as stemming from the interaction between nonoptimal contexts with standard human language processing – in isolation, therapeutic change might seem to be a daunting, if not impossible, task. Contexts cannot necessarily be changed without experiential avoidance, and human language is paramount to how an individual understands and interacts with both the outside world of the interpersonal and physical environments and the inside world of the self. Faced with the situation of conflict between resorting to experiential avoidance or somehow getting rid of human language, individuals may think that their condition is hopeless. This exact point becomes the ground for the first stage of ACT, which is referred to as *creative hopelessness* (Hayes et al., 1999). Creative hopelessness is a challenge to the stereotypical change agenda:

> This is a difficult insight because the alternative is not obvious. Superficially, the literal alternative would be to "stop trying to get rid of psychological pain," but if one did so in order to feel better, one would be doing so to rid of psychological pain, and thus the struggle would not have stopped. (Hayes, 2002, p. 60)

It is also in this stage that ACT therapists begin to introduce the common intervention strategies of paradoxical and process-oriented language. In ACT behavioral terms, creative hopelessness starts the process of undermining reason giving, blocking experiential avoidance, and disconnecting language from its normal, literal functions (i.e., cognitive defusion), all of which are done through the use of paradoxical language and exploration of metaphors in combination with relating to the life experiences of the client (Hayes, 2002; Hayes et al., 1999).

In the next stage, the "unworkable agenda" identified in the first part of ACT treatment is based on an outlook of control and avoidance. In this stage, the cultivation of creative hopelessness is given more form by conceptualizing it in the framework of how control tends to be more of the problem than the solution. *Willingness* is offered and explored as an alternative to control. Here, willingness – the term to be used with clients instead of *acceptance* at this stage – is understood as the level of openness one has for experiencing present events as they happen when they happen (Hayes et al., 1999). In this stage, ACT therapists facilitate experiential practice in letting events and situations happen as they will, so that other ACT interventions, such as cognitive defusion in the next stage, can be used to change the experience of those events.

In the stage of cognitive defusion (also known as *deliteralization*), ACT therapists focus on weakening and diminishing the relationship between language and the literal meaning given to language. The common strategy is to recognize that words are just words (i.e., "mental" or verbal events) and not facts, something which people are unaware of explicitly and goes unchallenged in daily life. An illustrative exercise used to facilitate

this strategy is what is known as the *Milk, Milk, Milk Exercise*, when the client first is asked to say the word "milk" and then process what thoughts and experiences arose from that word. Then, the client is asked to repeat the word "milk" repeatedly, often with increasing speed. Afterwards, the client and therapist process what thoughts and experiences arose from that part of the exercise. The point of the exercise is to loosen the literal associations and make explicit the distinction between the triad of language: language as sound (e.g., "milk"), language as word (e.g., m-i-l-k), and language as experiential symbol (e.g., cold, creamy, white liquid that one may have in his/her refrigerator; Hayes, 2004b; Hayes et al., 1999).

Next, ACT therapists help the client contact a sense of self that is distinct from programmed reactions and literal beliefs about the self (Hayes et al., 1999). In this stage ACT therapists are interested in exploring and differentiating between three major senses of self: conceptualized self (i.e., the sense of self constructed by ourselves), ongoing self-awareness (i.e., the sense of self that engages in self-knowledge and deep introspection), and observing self (i.e., the sense of self that provides a perspective with regards to metacognition). The objective in this stage is to shift attention from the conceptualized self, that sense of self that most people are intimately familiar with, to the observing self. The observing self provides a present-oriented context that is free from personal conceptualization and is not threatened by difficult psychological content. Establishing this sense of self facilitates cognitive defusion and continues to cultivate willingness to experience whatever events arise.

With the next stage, the ACT therapist takes all of the psychoeducation, skills

training, and experiential work done up to this point and applies them directly into the life of the client. By engaging in values work and interventions, direction and motivation for treatment are provided. Wilson and Murrell (2004) acknowledge that the common ACT intervention genres of exposure (i.e., willingness/acceptance) and cognitive defusion are utilized "when there is any event that generates narrow and inflexible patterns of behavior" and when those patterns are "obstacles to our clients moving actively in the direction of a chosen value" (p. 134). With values identified, clients can see the overt choices that they must make in their daily life with regards to their particular problems.

The next stage is merely a continuation of values work. Behavioral commitment strategies are cultivated in order for the client to behave in accordance with the chosen values from the assessment stage. Here, willingness as a "whole act" as opposed to sequential steps that are successful by varying levels of situational magnitude, is emphasized, a willingness to be open to what happens. Combined with a commitment to a valued life direction, the ACT therapist helps the client to focus on making valued choices and acting on those choices. The FEAR algorithm is presented again, this time as a list of barriers to experiential willingness that the client can use when self-monitoring their responses to events: *fusion* with thoughts, *evaluation* of experiences, *avoidance* of experiences, and *reason giving* for behavior. In addition, the ACT algorithm is presented as a guide in managing events: *accept* reactions and be present, *choose* a valued direction, and *take* action (Hayes et al., 1999).

In the end, change within an ACT perspective is understood as a process of challenging the habitual, verbally-driven ways of thinking, and shifting one's experience of

events and situations from cognitive fusion of thought and self to relying upon and assessing direct experience. Using personal values and framing the entire process as a system of present-centered awareness, decision-making, and commitment to action makes the treatment more concrete, pragmatic, and workable for the client. It also provides the active blueprint for the theory of health that ACT therapists espouse, reformulating how individuals regard themselves and their environments.

Gestalt Therapy and ACT in Relation

It is no secret that the originators of both Gestalt therapy and ACT were influenced by Buddhist meditative philosophy when developing their respective approaches: Fritz Perls traveled to Japan to learn about Zen Buddhism (Crocker, 2005), while ACT developers relied heavily upon parallel concepts in Buddhist mindfulness and theories of self (Hayes, 2002). Furthermore, I assert that these two orientations approach therapeutic health and change from a more holistic framework than is typically seen in other psychological approaches. Briefly, Gestalt therapists hold to a notion of health based on a freely flowing and naturally exciting cycle of experience (i.e., figure formation and destruction) with change conceptualized through the their paradoxical theory of change. ACT therapists approach health from their standpoint of the assumption of destructive normality (which also explains the role of human suffering in general) and that change is initially facilitated in mindfully accepting things as they are, challenging the viewpoint constructed by the logic of human language. These similarities, along with other parallels, occur in the foundations and guidelines of those approaches. However, an examination of other aspects of the underlying philosophy and theory of Gestalt therapy and ACT and how the two approaches are applied and practiced leads to the conclusion that they are distinct approaches to mental health.

Parallel Theoretical and Philosophical Threads

As intimated in their individual presentations, Gestalt therapists and ACT therapists both emphasize building awareness of the present state of affairs. For the Gestalt therapist, this takes the form of increasing a client's awareness of creative adjustments, previously formed, that are now carried out indiscriminately and out of awareness. For the ACT therapist, this takes the form of being mindful of and challenging the dominant (and occasionally destructive) elements of behavior that rely upon rule governance through the system of human language (see Skinner, 1969, for more on rule-governed behavior and contingency-shaped behavior). In both cases, awareness is being developed towards behaviors that have avoided direct attention.

The natural and inseparable next step to the awareness-building process is how individuals apply that awareness to directly shape active participation in the world. Therapists of both orientations recognize that awareness is not a passive characteristic that cures in and of itself. This idea of awareness fits more of the traditional psychoanalytic concept of *insight* rather than what is meant by *awareness* (cf. Freud, 1938/1995). Awareness is implicitly understood by therapists of both approaches to be a process-product concept: awareness as both the outcome and the means to reach that outcome (e.g., Hayes, 2004b; Naranjo, 1970). Awareness in Gestalt therapy is only true awareness if it is expressed through action, which is the thrust of the therapist's implementation of experiments. ACT therapists understand awareness as incorporated into acceptance (or willingness), a particular discernment into being open to how things are and working from that point. Through the lens of awareness or mindfulness, therapeutic change for both

approaches begins, and the process gets explored, refined, and expressed through an active application of that awareness.

Context and subjective meaning are another commonality between Gestalt therapy and ACT. Though very few clinicians from any therapeutic orientation would hold that individuals behave in a vacuum – where the particular situational and historical context is irrelevant to the formulation and expression of behavior – Gestalt therapists and ACT clinicians make this point explicit in their systems. The field theory of Lewin (1951) is the basis for Gestalt therapists' theory of context. In general terms within Gestalt therapy, a field is defined as "a totality of mutually influencing forces that together form a unified interactive whole" (Yontef, 1993, p. 297), though other Gestaltists recognize that the particular field being discussed must be defined and redefined based on context and purpose (Parlett, 2005). Field theory is the recognition that various situational and historical aspects and influences act to produce a particular behavioral outcome. That is, by changing the conditions of the field, the unique behavior evoked by an individual will change. Furthermore, Gestaltists tend to move away from merely addressing the content and form of the client's presented concerns and difficulties, towards exploring the process and meaning as an index of overall themes (or patterns) in response to the field.

Subjective meaning is nearly synonymous with the Gestalt philosophical foundation of phenomenology. As elaborated by Spinelli (as cited in Crocker, 2005), the phenomenological process consists of three basic guidelines: the bracketing off of evaluations of interpretations of reality as either true or false (i.e., *epoché*), the description of experience over interpretation of experience, and the avoidance of ranking

any one particular element of experience as more important than the other (i.e., horizontalization). Although Gestalt therapists generally intervene in therapy by sharpening or clarifying a figure presented by the client and may have speculations or hypotheses about their clients related to such figures, Gestalt therapists hold loosely their "working hypotheses" and in-session evaluative assessments about the client, using these elements as a fertile ground from which therapeutic work may progress through continual revision of those elements (Crocker, 2005). The meaning that the therapist may deduce from work with a client is only secondary and supportive to the meaning that the client derives and recognizes through awareness. Gestalt therapists' experiments are also framed in this manner, as a creative intervention to garner awareness of the client's process, with the therapist lacking any true agenda as to what the experiment is to achieve (Zinker, 1977). Experiments are not a mode in which therapists implant their own agendas and goals onto the client, but are an avenue for the client to become more aware of their own agendas and goals.

ACT therapists address context implicitly through their philosophical foundation of *functional contextualism* (Hayes et al., 1999). Contextualists hold to understanding the entirety of an event as well as being sensitive to the manner in which situational and historical elements shape the event. Behavioral goals are acknowledged to come from the subjective truth of the individual and are not judged in any objective manner. However, evaluation of this truth is related to how effective the behavior is in reaching the desired goal. This general contextualist system becomes "functional" with a focus of behavior analysis, namely the integrated goal of "prediction and influence of events" (Hayes et al.,

1999, p. 22). In other words, behavior analysts have the goal of being able to observe, predict, and explore how certain events evoke particular outcomes, and how that overall system can be altered based on particular values or desired goals. The active role of the ACT therapist is attempting to change the function of private experiences (e.g., thoughts and feelings), rather than addressing the form that private experiences take (a common therapeutic approach in cognitive therapy and traditional behaviorism; Hayes, 2004a; Hayes et al., 1999).

Again, the ACT therapist is not concerned with debating or challenging an individual client's subjective truth, but with emphasizing how certain value-based life choices are working effectively or successfully for the individual. ACT therapists refer to this nonontological approach as the *pragmatic truth criterion* of contextualism (Hayes et al., 1999). ACT therapists use the embedded values work to facilitate the process of identifying what clients desire in their lives and how workable present behaviors and private experiences are in achieving or maintaining those goals (Wilson & Murrell, 2004). The challenging of the standard change agenda that ACT therapists address in the onset of treatment is in the service of clarifying clients' own subjective truth and meaning. The therapist's analytic goals in therapy are understood by the ACT developers to be in the service of facilitating the achievement of the client's goals and not to supplant the client's goals with the therapist's agenda (Hayes et al., 1999).

Contrasts in Theoretical Application and Intervention

Both Gestalt therapists and ACT therapists understand that they adhere to practical philosophical and theoretical systems, not merely protocols of comprehensive techniques. The emphasis on creative process by Gestalt therapists (Zinker, 1977) and the encouragement of adding to the intervention repertoire, as well as using the therapy functionally (as opposed to using it topographically; Hayes et al., 1999), by ACT therapists show that there are strong, fixed processes in both approaches and that therapists can be flexible in the manner in which those processes are presented in session. Despite this recognition, there are significant thematic differences in the actual application of theory and philosophy, as well as the common interventions taught in each orientation.

The primary thematic contrast between Gestalt therapy and ACT is one of orienting perspective. I will differentiate the perspectives of each therapy through the use of the terms *phenomenological perspective*, which describes the Gestaltist's thematic orientation, and *paradoxical perspective*, which describes the thematic orientation used by the ACT therapist. By using these terms, I am not arguing that Gestalt therapists do not use paradox as an intervention, nor that ACT therapists do not have any phenomenological understanding with regards to their treatment. Rather, the differentiation I am providing relates to the primary thematic perspective that guides the application of theory and philosophy and surrounds basic intervention models with each orientation.

Utilizing a phenomenological perspective, Gestalt therapists may appear to be less directive with their clients than other orientations. From a Gestalt framework, the figures

of interest of the client are important in both cultivating basic therapeutic rapport as well as managing presenting issues. Though the Gestalt therapist may suggest potential figures to follow, some of which are the therapist's own figures of interest, in the end, it is the client that decides to either accept an offered figure or reject it for another. Even in the acceptance of an offered figure, the therapist may explore the process that took place in the agreement, especially if an emerging pattern is observed.

The phenomenological perspective ties into the Gestalt ideas of organismic self-regulation and the paradoxical theory of change. Specifically, Gestalt therapists avoid forcing clients to topics or issues that those clients are not interested in or ready to address. This falls in line with the notion that individuals naturally adjust and adapt to their environmental circumstances. When the proper field conditions are in place, particular outcomes will emerge, and this is especially true for the field of the therapy room where client and therapist interact. In attending to figures present in the moment, client and therapist address the phenomena or processes that have been constructed that inhibit or lessen contact, allowing the cycle of experience to flow more naturally and freely, with novel and exciting figures of interest developing after the destruction of older and previously attended to figures. All of these processes fuel and are fueled by the interaction of client and therapist in a phenomenological perspective.

The paradoxical perspective for ACT therapists involves the active challenging and presenting of paradoxical situations. Considering that the object being challenged is rule-governed behavior as facilitated by human language, a more directive approach by the ACT therapist is required in order to loosen literal meanings and address linguistic

relationships. Sharp, Wilson, and Schulenberg (2004) identify two primary forms of paradox used in psychotherapy, one of which is favored by ACT therapists in their paradoxical perspective. The favored paradox for the ACT therapist is *inherent paradox*, which is a verbal event that contains a contradiction between its literal properties (i.e., behaviors that are expressed from established rules, or rule-governed behaviors) and its functional properties (i.e., behaviors that are expressed on the basis of particular situations, or contingency-shaped behaviors). An example of an inherent paradox is the command to "try hard to be spontaneous." Spontaneity is a contingency-shaped behavior, but deliberate action (i.e., trying hard) is rule-governed. By extension, the underlying theory of therapeutic change that ACT therapists work from is also an inherent paradox: The usual attempts to change the form of or avoid negative experiences brings about those negative experiences that are trying to be changed or avoided (Hayes et al., 1999). ACT therapists prefer inherent paradox because its repeated use aids in loosening "the grip of literal language by highlighting the fact that literal language is useful in some contexts and not in others" (Hayes et al., 1999, p. 85).

The other paradoxical intervention, *constructed paradox*, is the dominant form of paradox used by clinicians in other psychotherapeutic systems, such as logotherapy (although logotherapists also uses inherent paradox as well; Ascher, 1989). A constructed paradox is defined by the therapist using the "social demand of rule-following which creates a situation in which the individual must either follow or resist the rule, and in either case, the effects are most likely beneficial" (Sharp, Wilson, & Schulenberg, 2004, p. 947). The example given by Hayes et al. (1999) involves the use of a constructed paradox to a

rebellious adolescent with problems with noncompliance, namely being told by the therapist to disobey the therapist. In response, the adolescent could either break the rule, which would mean that the adolescent would obey the therapist and become more compliant, or the adolescent could follow the rule, which would mean that the adolescent became compliant to the therapist's instruction. ACT therapists tend to avoid using constructed paradoxes primarily since such paradoxes have a focus of symptom elimination that would not address the problematic change agenda that provided the symptom in the first place, even if the symptom in question is eliminated through the use of the paradox. Also, therapists who use constructed paradoxes depend upon social demands and rules that lead to compliance or resistance, which ACT therapists view as a source of clinical difficulty (Hayes et al., 1999).

The differences in these two forms of paradoxes are important in understanding how the paradoxical perspective of ACT differs from other orientations that may rely upon paradoxes. By definition, constructed paradoxes are based in a social system where the client is either complying or resisting the therapist, but in either case is engaging the therapist through a particular social demand. The constructed paradox is typically a command or suggestion that can be enacted, despite whether one follows it or not. Conversely, inherent paradoxes do not rely on any social system and are typically difficult, if not impossible, to carry out literally. Where the clinician's use of constructed paradox is to counteract particular symptomatic behavior, the therapist's intent with the use of inherent paradox is to challenge the change agenda as an element of creative hopelessness and the prerequisite to cognitive defusion. However, in both cases, the presentation of the

paradox involves a very directive approach from the therapist that does not necessarily consider the explicit experience of the client.

Towards an Integration

Despite the variety of strengths and benefits that Gestalt therapy and ACT both have as effective treatments, both orientations have shortcomings and less-addressed areas. I will explore one particular shortcoming from each orientation, discussing how the therapists of one orientation address that particular shortcoming within their own approach, and argue that the manner in which those therapists manage the shortcoming could be applied to the perpetuated deficit in the other orientation. The deficit for Gestalt therapists that I will directly address is the problem they face in being recognized and assimilated into managed care systems as viable treatment providers, primarily due to the lack of a systematized intervention framework and an overall qualitative approach to empirical research and the implementation of research findings into clinical interventions. The deficit for ACT clinicians that I will focus on is their partial importation and utilization of humanistic concepts in their approach. I will argue that ACT therapists lack a substantial element in fully harnessing and implementing a humanistic approach, which may cause confusion in how ACT clinicians understand and use their treatment strategies.

Gestalt Therapy as a Behavioristic Phenomenology

Contrary to popular conception, Gestalt therapists deal with behaviors in session as much as behavior therapists do. Kepner and Brien (1970) argue that the Gestaltist goes beyond the behaviorist with regards to treatment involving behaviors, citing that

experience is a behavior that is not addressed by traditional behavior therapists. They also state that Gestalt therapists are not necessarily interested in behavioral analysis (as this term is commonly used in the psychotherapeutic literature) but more on phenomenological exploration. Despite this argument, many managed care providers favor the work of cognitive and behavior therapists over the treatment offered by Gestalt therapists. To understand the foundation of managed care, which is derived from the perspective of health and healing from a medical model, managed care providers have placed a premium upon empirical research and articulated, scientific mechanisms within the psychological dimension. Cognitive and behavior therapists and researchers have been able to thrive in such an environment, but Gestalt therapists have hindered the acceptance of their trade in this system with their position that therapy as more of an "art" than a "science" and a research orientation that is more qualitative in nature rather than quantitative (Brownell, 2005; cf. Strümpfel, 2004). Brownell (2005) outlines three elements set forth by managed care providers that tend to be obstacles for Gestalt therapists in plying their trade: efficiency, effectiveness, and accountability.

I will argue that efficiency is the primary element in the workings of managed care, as profits by such agencies are maximized with brief or short-term treatments, as opposed to long-term therapies. This is not to imply that Gestaltists only engage in long-term therapy, but time is not usually an issue for most Gestalt therapists (Brownell, 2005; see Houston, 2003, for more on brief Gestalt therapy). Effectiveness in the context of managed care is almost equivalent to efficiency, but is differentiated by the factor of empirical support, which requires operationalized definitions and measurable objectives

and outcomes. Gestalt therapists tend to avoid applying quantitative measures to outcomes that they conceive as being qualitative in nature, something which has delayed more voluminous Gestalt therapeutic research (cf. Strümpfel, 2004). Accountability refers to the records and documentation that are required by managed care, especially redundant documentation, and the inclusion of specific data, even if such information is not necessary for the therapist's clinical judgment or in-session interventions (Brownell, 2005). Instead, the trend for Gestalt therapists is to focus on information that is directly relevant to in-session work, and some Gestaltists will not use psychological tests in clarifying diagnoses or measuring treatment progress (cf. Brownell, 2002). If certain pieces of information have no direct bearing on the work being done in session or the context for conceptualizing the client's case, Gestaltists would regard it as extraneous and unnecessary.

Gestaltists could balance meeting managed care criteria and maintaining their theoretical orientation by becoming well-versed in the foundations of cognitive and behavioral therapies. Extrapolating from Brownell (2005), cognitive and behavioral interventions and mechanisms are merely theoretical reformulations of concepts that Gestalt therapists have identified and conceptualized from their own framework. The key in using reformulated terminology is that Gestalt therapists must find a consistent clinical theory that matches their own with regards to mechanisms or interventions. For instance, to label "topdog-underdog self dialogues" as "automatic thoughts" from a CBT perspective would not be ethically or clinically sound unless the underlying theories correspond to each other. Such an understanding can facilitate how Gestaltists can

incorporate behaviorally-informed elements into such practices as treatment planning, formal assessment and diagnosis, assimilation of evidence-based interventions, and documentation (Brownell, 2002, 2005). Gestaltists would need to find corresponding and consistent orientations from which to expand clinical understanding. I argue that a good place to start is with acceptance and commitment therapy.

My argument for using ACT as a behavioral template for Gestalt reformulations comes from the parallels of these approaches. Where Gestaltists seem to find difficulty in operationalizing and quantifying, ACT therapists have been able to work around quantification and still work from a holistic model of health and change. ACT therapists acknowledge that they do not have a monopoly on the notion of experiential avoidance, and recognize that Gestalt therapists have their own understanding of experiential avoidance involving what Greenberg and Safran describe as a dysfunction caused "when emotions are interrupted before they can enter awareness" (cited in Hayes et al., 1999, p. 58). Gestaltists and ACT therapists both seek to bring awareness to that which is presently being avoided or unattended. Exposure as it is understood generally by ACT therapists is an exposure to experiences that have been evaluated as negative or problematic before they are actually directly experienced. In addition, acceptance-building in ACT is the logical extension of such exposure. Being open to how things are at a particular moment allows for the ability to make clear choices and act, instead of debating and/or distorting the present moment. ACT therapists use values assessment to provide motivation and direction that is applicable and tailored specifically to the client's own unique worldview. Phenomenological awareness-building, which is a staple in Gestalt sessions, is a

combination of the exposure and values work within ACT, while the paradoxical theory of change and Gestalt experimental interventions gain behavioral elaborations with acceptance and willingness interventions. Though the differences that might be apparent in the terminologies (and even the approaches themselves) are subtle, the fact that ACT therapists have formulated their treatment on a novel and rigorous behavioral philosophical and theoretical foundation (cf. Palmer, 2004a, 2004b) allows ACT to be accepted in many of the same situations that CBT therapists have been accepted, including by managed care companies. Many Gestalists already support the assimilation of Gestalt concepts with findings in experimental psychology (e.g., Burley, 1998; Burley & Freier, 2004) as well as integrating psychological assessment into Gestalt work (e.g., Brownell, 2002), and the conceptualization of holism and acceptance that ACT is founded upon also fits well with the theoretical framework of Gestalt therapy.

ACT as a Humanistic Behaviorism

As I have intimated throughout this paper, the general trend among ACT practitioners has been towards elements that have typically been considered the domain of humanistic psychotherapists. Although ACT therapists explain processes through a behavioristic framework and language, they loosen their sense of agenda in therapy. In part, this is due to the fact that ACT therapists realize that control strategies are problematic (Hayes et al., 1999), but this loosening is also due to an overall shift in approach from the Skinnerian "prediction and control" model (Skinner, 1953) to a contextualist "prediction and *influence*" model. Moving from control, which includes in its

connotation the "elimination of behavioral variability in an absolute sense" (Hayes et al., 1999, p. 22), towards influence allows for the power and motivation to come from the client with regards to treatment. Therapists, guided by their clients' values, mediate the use of a more directive approach that is inherent in a paradoxical perspective such as ACT. Though other CBT therapists may make a similar claim, ACT therapists differentiate themselves by not judging or evaluating the client's specific values as they impact treatment, but by assessing how treatment strategies (ACT or otherwise) affect the successful working of those values (Hayes et al., 1999; Wilson & Murrell, 2004).

As mentioned earlier, ACT researchers and therapists were not the first to recognize and address the phenomenon of experiential avoidance. ACT therapists conceptualize experiential avoidance in much the same manner that Gestaltists understand "unfinished business" or incomplete figures that recede into the background. In a sense, Gestalt therapy has always been working with experiential avoidance, which is a priori in the paradoxical theory of change. Therapists from both orientations would agree that experiential avoidance is not always a nonoptimal response to situations, and would also agree on most of the situations in which experiential avoidance is not beneficial (and even destructive) to the individual.

For instance, ACT therapists realize that many private experiences (e.g., anxiety) are not usually rule-governed behaviors, which is to say that individuals do not routinely assess and establish, for example, what emotional reactions they will have to a given situation until they directly experience the situation. An individual will discover that experiential avoidance is not an adequate solution to a situation that does not involve a

rule-governed behavior. In this general example, an individual using experiential avoidance would attempt to suppress or otherwise avoid anxiety, and would also have to contend with having anxiety about having anxiety (i.e., the initial anxiety reaction from the situation). Since individuals using this strategy attend to denying what is occurring instead of attending to the present state of affairs, the inadequacy of avoidance is revealed.

Gestalt therapists have addressed this particular process intimately by elucidating their change theory and how it relates to their heuristic of contact boundary phenomena. For instance, retroflection of an emotional response in a given situation is a disturbance in addressing a particular want or need (e.g., expression of anger). As energy that an individual would typically put out into the environment is suppressed or redirected back at the individual, the emotional response of anger does not dissipate. Without adequate closure, the anger response recedes into the background incomplete, still requiring attention and proper closure. This receded figure can then continue to exert influence as other figures arise, and its influence may prevent those new figures from receiving proper attention and closure.

The shift for ACT therapists from a traditional CBT perspective is that they regard covert and overt behaviors as dysfunctional or nonoptimal with regards to the subjective experience of the client, or, in other words, how those phenomena facilitate or hinder personal life values (Wilson & Murrell, 2004). With this conceptualization as the base of treatment, ACT therapists reframe the clinical scenario as a lack of discernment and awareness about how certain behaviors are implemented given the context of situations. This includes individuals denying their direct experience in favor of private evaluations as

well as a difficulty in acting from a personally-committed standpoint. ACT therapists understand that this process of unawareness, nonacceptance, and noncommitment is not the problem, but rather a nonoptimal solution to a problem. As such, the therapist's role in treatment is not to eliminate the process from the client's repertoire (as is often the case with the interventions used by CBT clinicians) but to come up with a more functional solution in dealing with situations. ACT therapists recognize that the individual may find generally dysfunctional responses to be quite optimal in certain specific instances, or that the response may be necessary for the individual depending on their values and needs. ACT clinicians have leverage in collaborating with the client in finding more functional solutions with their contextualist approach and working with the clients' values.

Although such movements in the therapy do signal larger paradigmatic shifts of the therapeutic philosophy and theory, ACT therapists still follow a highly paradoxical perspective that puts them in a much more directive and authoritarian position in relation to their clients. ACT therapists are always balancing guiding clients through the structured stages of ACT and engaging their clients with the aid of the clients' own established values. Implicit in the change theory of ACT is the idea that the therapist must challenge the standard change agenda that the client has been following since it is this change agenda that is problematic and the client knows no other way of enacting change. It is then the clinician's role to provide education and intervention about an alternate manner of enacting change, one that focuses on the interaction between human language and patterned behaviors.

A more client-based approach can be compromised as the ACT therapist

progresses through delineated stages. Indeed, ACT clinicians assert that "[m]inds do not know what is good for humans" (Hayes et al., 1999, p. 71), which would necessitate that therapists must do the majority of the guiding and challenging, at least initially. Hayes et al. (1999) acknowledge that analytic goals in therapy are only useful in reaching the client's values-based goals and should never supersede the client's goals in any ultimate sense. However, ACT therapists can be faced with problems if clients refuse acceptance or participation in stages previous to the values assessment. In that situation it would seem that the analytic goals of the therapist must become the primary goals for the client in order to reach the stage where the client builds his or her own goals from his or her own values and life priorities. By adhering to an approach with clearly outlined stages of therapeutic development, therapists and clients may struggle to determine what their roles are in session, as well as struggle with which goals and objectives trump which others. This also may present the ACT clinician with the added responsibility of providing the energy and movement of sessions, since clients are only motivated to remain in session by valued goals in the later stages of ACT. With this state of affairs, clients may feel less involved in the therapy, which may reduce ACT interventions as merely intellectual exercises, something which the ACT developers actively denounce (Hayes et al., 1999, p. 275).

The advantage that Gestalt therapists have in this domain is that Gestalt therapy itself lacks any system of stages in treatment. Therapy is realized as a collaborative process between therapist and client, and Gestaltists always fall back on meeting clients where they are (i.e., phenomenology). Gestaltists attempt to let the client guide the therapy session,

but are prepared to be more directive if that is what the client needs at that moment.

It is difficult to know how efficacious and effective ACT would be if the stages-based system that is embedded in it were taken out. For many CBT clinicians, the structure of logically-progressing stages not only makes complete sense, but is dictated by experimental mandates. Thus, no studies have been conducted looking at utilizing ACT interventions apart from the stages they are presented in. A possible direction for ACT clinicians to explore may be to loosen their grip to their system of stages and engage clients with their repertoire of theory-based interventions at the pace of the client. Therapists who allow the therapy to be fueled by the energy of the client rather than produce the therapeutic energy themselves tap into an important humanistic element, one where the therapist facilitates not only an increased motivation in the client in reaching therapeutic goals but also the expression of the client's creative and active potential. In this regard, the clients may be excited by expressing and realizing their own humanity, as opposed to being viewed implicitly as a complex computer.

Summary and Conclusion

Therapists struggle to find a balance between optimal conceptualizations of health and change and the demands that third-party groups place upon treatment. Since the late 19th century, clinicians understood psychopathology and functioning in terms of the medical model provided by physicians and other primary care providers. However, as further research and theoretical refinement within psychology continued, therapists began to embrace more holistic and contextualistic models of mental health and therapeutic change. As this shift in thinking occurred, managed care providers also emerged as those who would influence – or, in some cases, dictate – how therapy is to be meted out. Again, therapists faced the dialectic of favoring quantitatively effective therapeutic strategies versus relying upon logistically practical intervention techniques.

A logical synthesis of this dialectic has been the development of empirically sound treatments that utilize the same mechanisms as those qualitatively effective strategies. Mindfulness is a recent "player" in that regard. Clinicians became interested in the concept of mindfulness, with its roots in Buddhist meditation. Mindfulness represented a new technique that had not been directly and wholly integrated into treatment, and also presented a novel philosophy and theory about the relationship of pain and distress. Clinicians began researching and instituting mindfulness-based interventions in client populations, initially as a way of managing stress and chronic pain (Kabat-Zinn, 1990). However, therapists began to broaden the applications of mindfulness into treating

depression relapse (e.g., Segal, Williams, & Teasdale, 2002), anxiety (e.g., Roemer & Orsillo, 2002), and even personality disorders (e.g., Linehan, 1993). Therapists held mindfulness to the same experimental rigor that had been applied to other interventions, sometimes with some difficulty (e.g., Brown & Ryan, 2004). It also became clear that the theory behind mindfulness as well as the manner in which the intervention was presented had more humanistic elements. As clinicians continued to research and apply mindfulness in therapy, some in the field observed this phenomenon as a potential paradigm shift within behavior therapy, called by some the third wave of behavior therapy (Hayes, 2004a, 2004b).

Hayes and his colleagues developed one of these new behavior therapies, acceptance and commitment therapy (ACT; Hayes et al., 1999), and combined the general philosophy and theories of behavior analysis with an experiential and process-oriented approach that had been the hallmark of many humanistic psychotherapies. As their new approach was derived from radical behaviorism, the ACT developers were able to able to gain some credence from managed care providers, since ACT was based on empirical and operationalized concepts present in cognitive and behavior therapies and had direct experimental links to other empirically-validated treatments.

At the same time, Gestalt therapists were trying to find their place in this state of affairs without compromising their therapeutic philosophy and theory. Although their theory and practice had changed and been refined since Gestalt therapy's emergence in the 1950s, Gestaltists were challenged by the strict acceptance criteria that managed care providers had put forth. For some Gestalt therapists, their solution to the dialectic of

quantitatively and empirically effective therapy versus qualitatively practical therapy was to translate their concepts and strategies into behavioristic language and to link their philosophies and theories with those that were empirically sound. However, mere transposition of terms is not adequate. The behavioristic orientation that these Gestalt therapists choose to provide a therapeutic template does not necessarily parallel Gestalt therapeutic philosophy and consistency is compromised and Gestalt therapy theory becomes arbitrary.

I have presented both Gestalt therapy and ACT as examples of holistic therapies and outlined their basic ideas with regards to mental health and therapeutic change. I have compared and contrasted these two approaches. I have explored how these approaches may be integrated in order to address their respective drawbacks and disadvantages. My goal has been to avoid presenting any definite answers. Rather, I have endeavored to present avenues of discussion and further research into how each of these approaches can be more effective in the domain of empirical research and acceptance into managed care and in the domain of improving the therapeutic environment to facilitate more human dialogue to improve overall treatment outcomes.

ACT therapists excel in the former, however their potential pitfall in therapy is the latter, which may lead to confusion and a disconnection between the underlying philosophy of ACT and its implementation with clients. Furthermore, I argue that for ACT clinicians to capture this lost aspect, they may need to investigate loosening their change agenda, as radical as it might be to the normal change agenda. Namely, ACT therapists may need to rely more on the interaction between themselves and their clients rather than

holding tight to their systematic presentation.

A primary concern for many Gestalt therapists is the dearth of empirical research and their exclusion from managed care panels. I argued that the strong parallels between the philosophy and theory of Gestalt therapy and ACT could lead some Gestaltists to utilize ACT as a template for translating their theory and practice into more behaviorally-oriented concepts. I would also propose that Gestalt therapists must engage in similar empirical research like their colleagues in cognitive and behavior therapies and seek out the behavioral grounding necessary to meet the acceptance criteria of managed care providers. Since the clinicians of these two approaches have similar underlying foundations for their interventions, philosophical and theoretical integrity and consistency is not threatened nor compromised.

At this stage, I am only presenting topics of discussion, exploration, and further study. For these ideas to have any merit beyond conceptual play, they must be taken up, practiced, and closely evaluated. In order to address the distress of individuals, therapists must adhere to therapeutic philosophies and theories that provide functional heuristics in conceptualizing health and change, as well as effective intervention strategies that cultivate such health and change. At the same time, it must be understood that orientations and approaches should not be seen as static entities, but ever-growing processes that are refined over time through experimental discoveries and clinical implementation. Thus, part of this developmental process is looking beyond the established borders of one approach to see other ideas and strategies that might improve that approach.

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